STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES
-

Medical Facilities Unit – Acute Care

General and/or Specialty Hospital

SECTION 1: Facility Information			
Facility Name:			
Mailing Address:			
City:	State:	Zip:	County:
Physical Address:			
City:	State:	Zip:	County:
Telephone No.: ( )		Fax No.: ( )	
Email Address:			

SECTION 2: Fees	
APPLICATION FOR GENERAL AND/OR SPECIALTY HOSPITAL	
License Type: ☐ Initial Application (fee $40 x Number of Acute Beds: _____) ☐ Renewal Application (fee $40 x Number of Acute Beds: _____) License Renewal Period (dates): _____ to _____ **Total Fee Enclosed for Licensed Capacity ……**	 $ _____ $ _____ $ _____
Make checks or money orders payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time. **Total Checks/Money Orders enclosed =**	**$ _____**

For questions regarding this program and/or application, please contact the following:
Department of Health and Human Services
Licensing and Regulatory Services
Medical Facilities – Acute Care Program
41 Anthony Ave; 11 State House Station
Augusta, ME 04333-0011

Tel: (207) 287-9300 Fax: (207) 287-2671 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: DLRS.MedFacilities@maine.gov

Office Use Only:
Check# _____ MO # _____ Amount $_____ Initials: _____ License# _____

SECTION 3: Facility Information (Use additional sheets, if necessary)

Owner of Hospital:

Operator of Hospital:

Non-Profit:	Proprietary:
Chief Executive Officer:	Title:

Locations. List any other hospital facilities at locations other than the above address, which are under the same ownership and governing authority.

	Name of Facility Telephone Number	Address
1.	_____ _____	_____ _____
2.	_____ _____	_____ _____
3.	_____ _____	_____ _____

Changes since last licensure.

Has the Hospital Charter, Constitution, or Bylaws been amended since last license application?

☐ No ☐ Yes, date on which current Hospital Charter, Constitution, or Bylaws adopted by Governing Authority: _____

Have the Medical Staff Bylaws been amended since the last license application?

☐ No ☐ Yes, date on which current Medical Staff Bylaws were approved by Governing Authority: _____

Accreditation: Please select all Accreditation Organizations that this Critical Care Access Hospital is accredited by.

☐ Joint Commission	Date of Last Survey: _____	Accredited for _____ years
☐ AOA	Date of Last Survey: _____	Accredited for _____ years
☐ Laboratory Accredited by C.A.P.	Date of Last Survey: _____	Accredited for _____ years
☐ Laboratory Accredited by Joint Commission	Date of Last Survey: _____	Accredited for _____ years
☐ Other: _____	Date of Last Survey: _____	Accredited for _____ years

SECTION 4: Facility Services

Total Number of Beds:

Number of Beds by Level of Care		Location (if other than main campus)
Acute Hospital Beds	_____	_____
Designated Swing Beds	_____	_____
Bassinets	_____	_____
Intermediate Care	_____	_____
ICU/CCU/SCU	_____	_____
Acute Hospital Beds*	_____	_____
Total Beds:	_____	
Number of Bassinets:	_____	_____

*not for use for over six months

Health Care Services Provided. Official license will be limited to health care services, beds, and bassinets applied for and approved.

- Section A, Daily Hospital Inpatient Services, complete the number of beds by category. This must match the number of beds in the previous section.
- Section B, Ancillary Services, are services that can be provided to either inpatients and/or outpatients. Select all that apply.

A. Daily Hospital Inpatient Services

Acute Care	11X Private No. Beds	12X Semi-Private No. Beds	15X Ward No. Beds	16X Other No. Beds
1. Surgical	_____	_____	_____	[redacted]
2. OB/GYN	_____	_____	_____	[redacted]
3. Pediatric	_____	_____	_____	[redacted]
4. Psychiatric	_____	_____	_____	[redacted]
5. Medical	_____	_____	_____	[redacted]
6. Isolation	_____	_____	_____	[redacted]
7. Detoxification	_____	_____	_____	_____
8. Alcoholic Rehab	_____	_____	_____	_____
9. ICU/CCU/SCU	_____	_____	_____	_____
10. Other Acute Hosp. Beds	_____	_____	_____	_____
Acute Bed Totals	_____	_____	_____	_____

	No. of Beds		No. of Beds
Swing Beds	_____	Intensive Care (20X)	
Coronary Care (21X)		General	_____
Myocardial Infarction	_____	Surgical	_____
Pulmonary Care	_____	Medical	_____
Cardiac Surgery	_____	Pediatric	_____
Other: _____	_____	Psychiatric	_____
Nursery		Neo Natal (Level II)	_____
Level I	_____	Neo Natal (Level III)	_____
Level II	_____	Burn Care	_____
Level III	_____	Trauma	_____
		Other: _____	_____

B. Ancillary Services (Select all that apply)

- ☐ Pharmacy (25X)
- ☐ Central Services (27X)
- ☐ Laboratory (30X)
  - ☐ Clinical
  - ☐ Anatomical Pathology
  - ☐ Hematology
  - ☐ Chemistry
  - ☐ Immunology
  - ☐ Bacteriology
  - ☐ Urine
  - ☐ Cytology
  - ☐ Other: _____
- ☐ Radiology-Diagnostic (32X)
  - ☐ Angiocardiography
  - ☐ Computerized Tomography Scan – Head
  - ☐ Computerized Tomography Scan – Total Body
  - ☐ Mammography
  - ☐ Angiography
  - ☐ Other: _____
- ☐ Radiology – Therapeutic (Radiation Oncology) (33X)
  - ☐ Radiation Therapy
  - ☐ Cobalt Therapy
  - ☐ Radium Therapy
- ☐ Nuclear Medicine (34X)
  - ☐ Diagnostic
  - ☐ Therapeutic
- ☐ Surgical Services (36X)
  - ☐ General Surgery
  - ☐ Organ Transplants
  - ☐ Open Heart Surgery
  - ☐ Neurosurgery
  - ☐ Orthopedic Surgery
  - ☐ Day Surgery
  - ☐ Other: _____
  - ☐ Laser Surgery (Equipment)
- ☐ Anesthesia (37X)
  - ☐ Anesthesia M.D.
  - ☐ Anesthesia C.R.N.A.
  - ☐ Acupuncture
- ☐ Blood Bank (38X)
- ☐ Oncology Service (39X)
- ☐ Respiratory Services (41X)
  - ☐ Inhalation Services
  - ☐ Hyperbaric Oxygen Therapy
  - ☐ Pulmonary function
- ☐ Physical Therapy (42X)
- ☐ Occupational Therapy (43X)
- ☐ Speech Pathology (44X)
- ☐ Emergency Room (45X)
  - ☐ Level I
  - ☐ Level II
  - ☐ Level III
  - ☐ Level IV
- ☐ Audiology (47X)
- ☐ Organized Outpatient Svcs (50X)
- ☐ Organized Clinics (51X)
  - ☐ Psychiatric
  - ☐ Surgery
  - ☐ Diabetic
  - ☐ ENT
  - ☐ Eye
  - ☐ OB/GYN
  - ☐ Orthopedic
  - ☐ Pediatric
  - ☐ Cardiology
  - ☐ Physical Medicine
  - ☐ Urology
  - ☐ Oncology
  - ☐ Ophthalmology
  - ☐ Other: _____
- ☐ Ambulance Service (54X)
- ☐ Medical Social Services (56X)
- ☐ Home Health Service (59X)
- ☐ Recovery Room (71X)
- ☐ Labor and Delivery (72X)
  - ☐ Labor Room
  - ☐ Delivery Room
  - ☐ LDR
  - ☐ LDP
- ☐ EKG (73X)
- ☐ EEG (74X)
- ☐ Nursery (76X)
  - ☐ Newborn
  - ☐ Isolation
- ☐ Ambulatory Surgery (77X)
- ☐ Renal Dialysis (80X)
  - ☐ Inpatient Hemodialysis
  - ☐ Inpatient Peritoneal Dialysis
  - ☐ Outpatient Hemodialysis
  - ☐ Outpatient Peritoneal Dialysis
  - ☐ Training Hemodialysis
  - ☐ Training Peritoneal Dialysis
- ☐ Other Services (90X)
  - ☐ Dental Services
  - ☐ Electromyography
  - ☐ Recreational Therapy
  - ☐ Ultrasound
  - ☐ Other Therapy: _____
  - ☐ Patient Education/Training
  - ☐ Podiatric Services
- ☐ Psychiatric/Psychological Svcs (91X)
  - ☐ Rehabilitation
  - ☐ Day Care
  - ☐ Individual Therapy
  - ☐ Group Therapy
  - ☐ Family Therapy
  - ☐ Bio Feedback
  - ☐ Testing
  - ☐ Electric Shock Treatment
  - ☐ Other: _____

Additional Information. Use the space below to elaborate on any of the answers given above or to make any pertinent remarks. Refer to each item number to which comments pertain.

_____
_____
_____
_____
_____
_____
_____
_____

SECTION 5: Submission

Submit your completed application with the following:

- A check or money order made payable to "Treasurer, State of Maine"
- A listing of outpatient departments/services and locations
- A listing of affiliates with addresses
- Results of any Accreditation Survey, if applicable

SECTION 6: Declaration

The applicant certifies that all information contained in this application is true and correct to the best of his/her knowledge.

The Department of Health and Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure.

I, _____, being duly authorized to assume responsibility for the conduct of the institution herein described, do hereby file this application for a license and do agree to assume responsibility that the institution will comply with all current regulations of the Department of Health and Human Services, as authorized by Title 22, MRSA §1964, Title 22; MRSA §1811-1821, and amendments and additions thereto.

_____	_____	_____
Print name of Chief Executive Officer	**Signature of Chief Executive Officer**	**Date**

Address of CEO, if different from above

Mailing Address:			
City:	State:	Zip:	County: